Local Governmental Agency:
Contract Number:
Period of Service:

NEW MEDI-CAL ADMINISTRATIVE ACTIVITIES
INVOICE for LOCAL GOVERNMENTAL AGENCIES

Program:
Claiming Unit:
Invoice #:

	COST CATEGORIES:	FORMULA alpha = line numeric = cost pool	CP#1 SPMP (Enter)	CP#2 Non-SPMP (Enter)	CP#3a Non-Claim. (Enter)	CP#3b (Formulas) Non-Claim. Bal. from Dir. Chg.	CP#4 (Formulas) DIRECT CHARGES ENHANCED	CP#5 (Formulas) DIRECT CHARGES NON-ENHANCED	CP #6 (Enter) Allocated Cost & Revenue
A	Salary	(Enter)				$0	$0	$0	
B	Benefits	(Enter)				$0	$0	$0	
C	SUBTOTAL	A+B	$0	$0	$0	$0	$0	$0	$0
D	Personal Service Contracts	(Enter)				$0	XXXXXX	$0	XXXXXXX
E	SUBTOTAL PERSONNEL	C+D	$0	$0	$0	$0	$0	$0	$0
F	Distribution %	E/(CP1...CP5)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	XXXXXXX
G	MAA Transportation	(From Direct Charges.)	XXXXXXXXX	XXXXXX	XXXXXX	$0	XXXXXX	$0	XXXXXXX
H	Other Costs	(Enter)				$0	XXXXXX	$0	
I	Costs to be Distributed	E6+H6	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXXXXX	XXXXXX	XXXXXXXXX	$0
J	Distribution of Costs	I6 x F	$0	$0	$0	$0	$0	$0	XXXXXXX
K	SUBTOTAL OTHER COSTS	G+H+J	$0	$0	$0	$0	$0	$0	XXXXXXX
L	Collapse CP#3b	E3b+K3b	XXXXXXXXX	XXXXXXXXX	$0	XXXXXXXXX	XXXXXX	XXXXXXXXX	XXXXXXX
M	TOTAL COSTS	E+K+L	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXX
N	% OF TOTAL COST	M/(CP1-CP5)	0.00%	0.00%	0.00%	XXXXXXXXX	0.00%	0.00%	XXXXXXX
	FUNDING SOURCE ADJUSTMENT:			ALL FORMULAS					
O	Funding Sources	From Funding Sources	$0	$0	$0	XXXXXXXXX	$0	$0	$0
P	Reallocated CP#6 Funding Sources	O6 X N	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX
Q	TOTAL FUNDING SOURCES	O + P	$0	$0	$0	XXXXXXXXX	$0	$0	XXXXXXXX
R	Non-Claimable Services Cost: CP#3	M3	XXXXXXXX	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
S	Non-Claimable Service Cost: CPs #1 & 2	M x (AL+AM+AN)/(AQ-AO-AP)	$0	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
T	Remaining Funding Sources CP#3	(Q-R)>$0	XXXXXXXX	XXXXXXXX	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
U	Distribution %	S1/(S1+S2);S2/(S1+S2)	0.00%	0.00%	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
V	Reallocated CP#3 Funding Sources	T3 x U	$0	$0	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX
W	Remaining Revenue	If M=$0 or V<S,Q;else,V+Q-S	$0	$0					
X	Revenue to Personnel Services	If E=0,0; else W * E/M	$0	$0					
XX	Revenue to Other Costs	If K=0,0; else W * K/M	$0	$0					
Y	Adjusted Personnel Services Cost	If (E-X)=0,0; else E-X	$0	$0					
YY	Adjusted Other Cost	If (K-XX)=0,0; else K-XX	$0	$0					
Z	TOTAL ADJUSTED COST	Y+YY	$0	$0	XXXXXXXX	XXXXXXXX	$0	$0	XXXXXXXX

	ACTIVITIES		(Enter) MEDI-CAL %	(Enter) ACTIVITY RESULTS PERCENTAGES SPMP	(Enter) NON-SPMP	INDICATE METHODOLOGY USED TO DETERMINE MEDI-CAL %
AA	Medi-Cal Outreach (A)	A	100.00%	0.00%	0.00%	
AB	Medi-Cal Outreach (B1)	B	0.00%	0.00%	0.00%	AC____ Other____
AC	Medi-Cal Outreach (B2)	B	0.00%	0.00%	0.00%	CWA
AD	Facilitating Medi-Cal Application	C	100.00%	0.00%	0.00%	
AE	Arranging for Transportation	D	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AF	Contract Administration A	E	100.00%	0.00%	0.00%	
AG	Contract Administration B	E	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AH	Program Planning & Policy Develop. (A)	F	100.00%	0.00%	0.00%	
AI	Program Planning & Policy Develop. (B)	F	0.00%	0.00%	0.00%	CWA___ AC___ Other___
AJ	MAA/TCM Coor./Claims Admin.	G	100.00%	0.00%	0.00%	
AK	MAA Implementation Training		100.00%	0.00%	0.00%	
AL	Other Programs/Activities		XXXXXXXXXX	0.00%	0.00%	CWA = County-wide Average
AM	Direct Patient Care		XXXXXXXXXX	0.00%	0.00%	AC = Actual Count
AN	Targeted Case Management			0.00%	0.00%	
AO	General Admin. Time		XXXXXXXXXX	0.00%	0.00%	
AP	Paid Time Off		0.00%	0.00%	0.00%	
AQ	TOTAL TIME		XXXXXXXXXX	0.00%	0.00%	

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$0

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ALL FORMULAS

	ALLOCATE ADMINISTRATION & PAID TIME OFF & APPLY MEDI-CAL %	(Formula - Disc Column)	Medi-Cal %	SPMP	1 Apply MC% SPMP (50%)	11 SPMP (75%)	Non-SPMP	111 Apply MC% Non-SPMP
BA	Medi-Cal Outreach (A)	{AA/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BB	Medi-Cal Outreach (B1)	{AB/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BC	Medi-Cal Outreach (B2)	{AC/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BD	Facilitating Medi-Cal Application	{AD/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BE	Arranging for Transportation	{AE/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BF	Contract Administration A	{AF/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BG	Contract Administration B	{AG/SUM(AA..AN)}xMC%	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BH	Program Planning & Policy Development(A)(enhanced)	{AH/SUM(AA..AO)}xMC%	100.00%	0.00%	XXXX	0.00%	XXXX	XXXX
	Program Planning & Policy Development(A)(non-enhanced)	{AH/SUM(AA..AN)}xMC% (less enh)	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BI	Program Planning & Policy Development(B)(enhanced)	{AI/SUM(AA..AO)}xMC%	0.00%	0.00%	XXXX	0.00%	XXXX	XXXX
	Program Planning & Policy Development(B)(non-enhanced)	{AI/SUM(AA..AN)}xMC% (less enh)	0.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BJ	MAA/TCM Coor./Claims Admin.	{AJ/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BK	MAA Implementation Training	{AK/SUM(AA..AN)}xMC%	100.00%	0.00%	0.00%	XXXX	0.00%	0.00%
BL	Other Programs/Activities	AL/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	XXXX
BM	Direct Patient Care	AM/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	0.00%
BN	Targeted Case Management	AN/SUM(AA..AN)	XXXXXXXXX	0.00%	XXXX	XXXX	0.00%	0.00%
BO	TOTAL			0.00%	0.00%	0.00%	0.00%	0.00%

ALL FORMULAS

	CLAIM CALCULATION:		SPMP	Non-SPMP	
CA	Federal Non-Enhanced Basis Cost Pool #1	Z x (BO1)+ YY x (BO11)	$0		
	Federal Non-Enhanced Basis Cost Pool #2	Z x (BO111)		$0	
CB	Federal Non-Enhanced Share	(CA1 or CA2) x 50%	$0	$0	
CC	Federal Enchanced Basis	Y1 x (BO11)	$0	XXXXXXXX	
CD	Federal Enchanced Share	CC1 x 75%	$0	XXXXXXXX	
CE	Direct Charge: Enhanced Federal Share	Z4 x 75%	$0	XXXXXXXXX	
CF	Direct Charge:Non-Enhanced Federal Share	Z5 x 50%	XXXXXXXXX	$0	
CG	FFP @ 50%	CB1+CB2+CF2		FFP @ 50%	$0
CH	FFP @ 75%	CD1 + CE1		FFP @ 75%	$0
CI	TOTAL FEDERAL SHARE	CG + CH	XXXXXXXX	XXXXXXXX	$0

Activity Percentages Determined by One Month Time Study Completed in _____(month/year)

For DHS Program use only

I certify that this claim and any adjustment(s) are in all respects, true, correc
supportable by available documentation, and in compliance with all
terms/conditions, laws and regulations governing its payment.
The final adjusted approved amount for this invoice is $_____.

Approved by:_____
Date_____
Print Name:_____

Print Title:_____

I certify under penalty of perjury that the information provided on the invoice is true and correct, based on actual expenditures for the period claimed, and that the funds/contributions have been expended, as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these claimed expenditures have not previously been nor will not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claim Act.

Typed name of signer

Signature

Date

Title

Department of Health Services
714 P Street, Rm 1140
Sacramento, CA 95814

INVOICE PREPARATION INFORMATION

Typed name of preparer

Classification

Telephone #

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